UNMC Nebraska Medicine

ADDENDUM G
Guidelines for Obstetric Care with COVID-19 Suspected or Confirmed Infection in the Operating Room

Created: March 28, 2020

A. Initial Triaging of procedures for the parturient with **known or suspected** COVID-19*

1. For patients with suspected COVID-19 infection (person under investigation i.e. COVID test pending or COVID infection confirmed), defer procedures until the COVID-19 test results are available, if possible.
2. If the procedure can be done at bedside; perform the procedure at bedside, using COVID PPE per protocol.
3. Considerations for routine obstetrical care:
    a. Admit parturient to isolation room, preferably one of the two negative pressure rooms on the OB ward (4422 and 4424) or the negative pressure L&D unit (UT 4E, rooms 4402-4410)
    b. Limit providers to absolute minimum
    c. Don all standard COVID PPE before entering the patient room.
    d. COVID 19 is not considered a contraindication for neuraxial anesthesia/analgesia
    e. Anesthesiology Consult required even if peripartum analgesia is not desired; early epidural should be encouraged to avoid needing general for possible C-section
    f. Proactively communicate with Obstetricians and OB nursing to avoid emergent sections if possible
4. Considerations for urgent procedures that cannot be deferred or done at bedside in negative pressure labor or COVID room (e.g., Cesarean section):
    a. Schedule the patient by calling **L&D Lead Nurse (531-557-3333)**
    b. Inform anesthesia care team leader that the patient is COVID-19 + or COVID-19 test pending.
    c. Procedures for COVID-19 positive/PUI parturients should be performed in OR 4338 if available.
    d. If neuraxial surgical anesthesia is not planned, consider intubating the patient in the negative pressure airborne infection isolation labor room prior to transport to the OR.
        i. Intubation should be done per COVID PPE standard. All staff should don COVID PPE as per protocol.
        ii. Limit individuals in the room to essential personnel only.
    e. If neuraxial surgical anesthesia is planned, patient will be transported to OR for C-section (per transport policy) from negative pressure labor room.

* EMR is the sole source of truth of a patient's COVID status.

i. Patient will wear a standard surgical mask in the operating room over any supplemental oxygen
ii. Neuraxial anesthesia will be utilized as appropriate
iii. If unable to use neuraxial anesthesia or if neuraxial technique is inadequate, the patient will be induced under general anesthesia in the operating room using appropriate PPE and technique as described below.

5. The ORs remain positive pressure. Keep all doors closed as much as possible to keep room pressures regulated.
6. If patient develops respiratory distress in the OR or if there is failure of a regional technique, intubate patients using appropriate PPE in the operating room. All personnel necessary for delivery should be in the operating room in COVID PPE. Personnel entering the OR suite immediately after an aerosolized generating medical procedure (AGP) is performed (e.g., intubation, extubation) should do so only in an emergency and must wear COVID PPE (N95 respirator plus eye protection or a PAPR, in addition to a gown and gloves. Ideally, personnel should wait 15 minutes before entering after intubation/extubation and then wear appropriate PPE based upon COVID risk flow diagram.
7. For Cesarean sections, the baby will be taken to the OR resuscitation room (adjoined to 4338) immediately after birth. If not already present, the NICU team will need to don COVID PPE prior to joining the baby in the resuscitation room.

B. Staffing of OB Surgical Cases

1. Staffing for the surgical case should be minimized to the following:
    a. Circulating Nurse
    b. Scrub Tech/Nurse
    c. 1 NICU staff or Stork nurse to take baby to resuscitation room
    d. 1 backup circulator/technician will be stationed in second OR to obtain supplies/equipment/blood cooler needed for the case and assist people with donning and doffing PPE
    e. Attending anesthesiologist/CRNA or resident
    f. Attending Obstetrician with one resident of appropriate seniority
    g. Relief for breaks should be provided only as necessary to decrease the number of people in and out of the room and to preserve PPE.

C. Transporting Patients with Known or Suspected COVID-19 Infection to the OR

1. If time allows, it is preferable for **all members of the obstetrical team** to meet and review the surgical and anesthesia plans, to ensure the room is ready, and all supplies, equipment, blood, and other materials are available in the OR and in working order. This team review will include, at minimum, the OB attending, the

* EMR is the sole source of truth of a patient's COVID status.

anesthesiology attending, the circulator and scrub, NICU representative/Stork nurse, back-up circulator/technician, and appropriate OB leadership.

2. The Time Out of the Universal Protocol can be used as a reference.
3. Nursing will call everyone for the briefing. In most cases the review will be led by the OB attending. Anesthesia will lead the discussion for aerosolized generating medical procedures (AGPs).
4. Patients will be transferred directly to the OR from negative pressure labor room or COVID ward room. No COVID-19+ or COVID-19 test pending patients will go to the OB PACU.
5. Pre op Transport team will include:
    a. Designated Transport OB Nurse AND Stork Nurse
    b. For intubated patients
        i. Anesthesia attending/CRNA or Resident
        ii. Designated Transport OB Nurse
        iii. OR Respiratory Therapist (if needed)
6. When transporting a patient:
    a. All persons involved in transporting a patient will obtain appropriate PPE outside of the patient's negative pressure room, and don PPE prior to entry into the patient's room.
    b. See hospital policy **IC04 Transmission-based Precautions/Isolation Precautions** for detailed patient transport guidelines.
7. If patient is intubated prior to transport:
    a. Consider switching patient to a portable ventilator in the negative pressure ICU room (clamping ETT briefly during switch):
        i. Ensure a high efficiency hydrophobic filter is in place between the ETT and Ambu bag/Jackson-Reese or ventilator to avoid releasing infectious material to the surroundings.
        ii. Do not use the single-limb transport ventilator.
        iii. Consider using the portable ventilator in the OR with TIVA to avoid disconnects
    b. Prior to entry into the patient's room, transport staff having direct contact with the patient will don an N95 respirator plus eye protection (face shield or goggles) or a PAPR, in addition to an isolation gown and gloves.
    c. Team member designated to interact with the environment will wear an N95 respirator.

D. Procedure Upon Arrival to Operating Room and During Surgery

1. COVID 19 ROOM signs will be posted on the doors to the OR suite to inform staff and minimize exposure.
2. A log will be placed on the exterior door to track all staff who enter the room.

* EMR is the sole source of truth of a patient's COVID status.

3. The Circulating Nurse, Scrub Tech/Nurse, Anesthesiologist, Attending Obstetrician/resident will all don appropriate PPE obtained in the OB OR area and wait for the patient's arrival in the OR.
4. The transporters and patients will enter the OR and allow the door to close.
5. Once the patient transfers to the OR table, the bed/gurney will be cleaned and moved to the appropriate location outside of the OR.
6. The circulator will remain clean and wear gown, gloves, eye protection and N95.
7. The Omnicell will be covered with a protective barrier. All needed supplies/meds should be set out before the case or available in emergency supply totes.
8. Use of double gloves is standard practice in the OR.
9. Before any AGPs (e.g., intubation and extubation) are performed, all OR personnel must don an N95 respirator plus face shield or a PAPR, in addition to gown and gloves.
    a. Once an AGP is performed, additional OR personnel entering the OR suite must don appropriate PPE outside of the OR.
    b. If not scrubbed during the intubation, sterile personnel should wait 15 minutes prior to entering the room after intubation to gown and glove.
    c. If extubation must occur in the OR (no negative pressure rooms available) and 15 minutes has passed since intubation, most personnel should leave the OR prior to extubation. The Attending Anesthesiologist or the Anesthesia Resident / CRNA and Circulating Nurse will remain in the OR for extubation.
11. If general anesthesia is <u>not</u> required, the patient will continue to wear the surgical mask throughout the procedure.
10. If general anesthesia <u>is</u> required, the Obstetrical team should be in the operating room prior to induction. All OR personnel must don an N95 respirator plus face shield or a PAPR, in addition to gown and gloves.
12. Consider disposable covers (e.g., plastic sheets for surfaces) to reduce droplet and contact contamination of equipment and other environmental surfaces.
13. Smoke evacuation electrosurgical pencils will be used to address the possibility of virus in electrosurgical smoke.

E. Post-surgical Procedures for Patients with Known or Suspected COVID-19 Infection

1. Doff gowns and gloves in the operating room and discarded into regular trash receptacle, then perform hand hygiene. Exit the OR with respiratory protection (face shields, N95 respirators or PAPRs) in place. N95 Respirators and PAPRs should not be worn outside the OR or procedure area.
2. Exit into the outside corridor.
3. If the patient will be immediately transported to an ICU, keep respiratory protection in place and don appropriate PPE.
4. **<u>The scrub person</u>**: At the end of the case, the primary circulator will bring the empty case cart into the OR. The scrub person will place dirty instruments in the case cart

* EMR is the sole source of truth of a patient's COVID status.

and spray instrumentation with approved enzymatic cleaner. The closed case cart will be wiped with LLD wipes prior to it being sent to the sterile processing department (SPD).

5. Patient should be recovered back in her negative pressure labor room or be transferred directly back to inpatient negative isolation room in the ICU if the patient came from (or is scheduled to go to) the ICU. If a negative pressure labor room is unavailable, then the patient will recover in the OR and be transferred back directly to the appropriate inpatient COVID isolation room.
6. Move the patient from the OR table on to a regular floor bed prior to the surgical and anesthesia team's departure.
7. Prior to assisting with transporting the patient back to the inpatient location, OR team members involved in the transport will don appropriate PPE as described in the Transport section above.
8. After completion of patient delivery to the receiving inpatient location, OR team members involved in the transport will immediately doff PPE and perform hand hygiene. Face shields and PAPR face shields should be cleaned with a disinfectant wipe outside the patient's room and staff should follow appropriate PPE reprocessing procedures.
9. After the patient has left the OR, leave the room closed for 30 minutes (achieves greater than 99.9% aerosol clearance). The OR suite can then undergo routine cleaning with an EPA-approved hospital disinfectant after 30-minute downtime. Technicians can use PPE routinely utilized for OR environmental cleaning and disinfection. It is **critical** that all horizontal and high touch surfaces are thoroughly wiped (e.g. procedure table, countertop, chair, patient care equipment, anesthesia equipment, etc.) with approved low-level disinfectant. The manufacturer's instructions for use **must** be followed (wet times) for disinfection to occur. After cleaning, room is ready for the next patient.

* EMR is the sole source of truth of a patient's COVID status.